1300.51.1. Individual Information Sheet

An individual information sheet required pursuant to these rules shall be in the following form:
CONFIDENTIAL

See Note to Item 5
STATE OF CALIFORNIA
Department of Managed Care

INDIVIDUAL INFORMATION SHEET
UNDER THE
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

(California Health & Safety Code Sec. 1340 et. seq.)

1. Applicant's legal name:

_____
Full Name – First Middle and Last Names

2. Exact full name of person completing this statement:

_____
Full Name – First Middle and Last Names

3. Physical Description:

Sex: _____ Hair: _____ Eyes: _____
M or F Blnd, Brwn, etc. Blue, Hazel, etc.

Height: _____ Weight: _____
Feet' – Inches" In Pounds

4. Birthdate:

Date of Birth: _____
Month Day, Year

5. Social Security Number or Taxpayer Identification Number: - -

_____

(Note: The inclusion of your social security number is not required but is voluntary. It is solicited pursuant to Sections 1344 and 1351 of the Health and Safety Code. It may be used to conduct a background investigation by the Department, the California Department of Justice Information Branch, or by other federal, state or local law enforcement agencies. This form, including the social security number, will be held confidential, but is a public record and available to the public pursuant to the Public Records Act (Gov. Code Section 6250), at the discretion of the Director.

6. Residence Telephone:

Phone Number: ( ) _____
Area Code

7. Business Telephone:

Phone Number: ( ) _____
Area Code

8. Current Residence Address:

_____
Street Address or P O Box Number

_____
City, State ZIP Code

9. Employment for the last 5 years (list most recent first and include any employment with a plan or any person or entity which is or was affiliated with a plan (Section 1300.45(c)):

From: _____ To: _____
Starting Date – Month / Year Ending Date – Month / Year

Employer's Name and Address:

_____
Employer's Full Name

_____
Street Address or P O Box Number

_____
City, State ZIP Code

Occupation: _____

Duties (Briefly describe):

_____

_____

_____

(Note: Attach separate schedule if space is not adequate.)

From: _____ To: _____
Starting Date – Month / Year Ending Date – Month / Year

Employer's Name and Address:

_____
Employer's Full Name

_____
Street Address or P O Box Number

_____
City, State ZIP Code

Occupation: _____
Duties (Briefly describe):

_____

_____

_____
(Note: Attach separate schedule if space is not adequate.)

From: _____ To: _____
Starting Date – Month / Year Ending Date – Month / Year
Employer's Name and Address:

_____
Employer's Full Name

_____
Street Address or P O Box Number

_____
City, State ZIP Code

Occupation: _____
Duties (Briefly describe):

_____

_____

(Note: Attach separate schedule if space is not adequate.)

10. Business contacts, dealings and affiliations (see section 1300.45(c)(2)) with health care service plans during the last 5 years (but including, for example, such roles as director, stockholder, consultant, manager, provider and supplier, and such dealings as sales, leasing, and any contractual relationships) (list most recent business contacts and dealings first):

From: _____ To: _____
Starting Date – Month / Year Ending Date – Month / Year

Plan's Name and Address:

_____
Plan's Full Name

_____
Street Address or P O Box Number

_____
City, State ZIP Code

Relationship: _____

Duties (Briefly describe):

_____

_____

_____

(Note: Attach separate schedule if space is not adequate.)

From: _____ To: _____
Starting Date – Month / Year Ending Date – Month / Year

Plan's Name and Address:

_____
Plan's Full Name

_____
Street Address or P O Box Number

_____
City, State ZIP Code

Relationship: _____

Duties (Briefly describe):

_____

_____

_____

(Note: Attach separate schedule if space is not adequate.)

From: _____ To: _____

Starting Date – Month / Year Ending Date – Month / Year

Plan's Name and Address:

_____

Plan's Full Name

_____

Street Address or P O Box Number

_____

City, State ZIP Code

Relationship: _____

Duties (Briefly describe):

_____

_____

_____

(Note: Attach separate schedule if space is not adequate.)

11. Have you ever had a certificate, license, permit registration or exemption issued pursuant to the Business and Professions Code or Health and Safety Code denied, revoked or suspended or been otherwise subject to disciplinary action, while you were in the employ of the applicant, or while you had a contract with the applicant as a provider or otherwise?

☐ Yes ☐ No

If "yes," state the date of the action and the administrative body taking such action.

Date of _____